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State of Indiana Individual Bill - Blue Retiree

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Anthem

Underwritten by Anthem Insurance Companies, Inc.

Your Health Certificate

Certificate of Coverage

(herein called the "Certificate")

Blue Retiree Plan

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

AICBL-RET02

1 CERTIFICATE

Welcome to Anthem! This Certificate has been prepared by Us to help explain your coverage. Please refer to this Certificate whenever you require medical services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Certificate is not a Medicare Supplement Certificate. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Plan.

The coverage described in this Certificate is subject in every respect to the provisions of the Group Contract pages issued to the Group. The Group Contract and this Certificate and any amendments or riders attached to the same, shall constitute the Group Contract under which Covered Services and supplies are provided by Us.

This Certificate should be read and re-read in its entirety. Since many of the provisions of this Certificate are interrelated, you should read the entire Certificate to get a full understanding of your coverage.

Many words used in the Certificate have special meanings. These words appear in capitals and are defined for you. Refer to these definitions in the **Definitions** section for the best understanding of what is being stated.

This Certificate also contains **Exclusions**, so please be sure to read this Certificate carefully.

President

Contents

2 MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, you have the right to:

- receive written documentation regarding rules and regulations of your health care benefits;
- be treated respectfully and with consideration;
- receive all the benefits to which you are entitled under your Certificate and Schedule of Benefits;
- obtain from your Provider complete information regarding your diagnosis, treatment and prognosis in terms you can reasonably understand;
- receive quality health care through your Provider in a timely manner and in a medically appropriate setting;
- participate with your Physician in decision making about your healthcare treatment;
- refuse treatment and be informed by your Physician of the medical consequences;
- express concern and complaints about the care and services provided by Physicians and other Providers to Us and to have Us investigate and take appropriate action;
- file a complaint with Us, to Appeal that decision as outlined in the **Complaint and Appeals Procedures** section of this Certificate, and to Appeal a decision to the Indiana Department of Insurance without fear of reprisal; and
- confidentiality and privacy.

As a Member, you have the responsibility to:

- use Providers who will provide or coordinate your total health care needs, and to maintain an ongoing patient-Physician relationship with that Physician;
- provide complete and honest information about your health care status;
- follow the treatment plan recommended by your Provider responsible for your care;
- understand how to access care in routine, emergency and urgent situations, and to know your health care benefits as they relate to out-of-area coverage, Copayments, etc.;
- notify your Provider or Us about concerns you have regarding the services or medical care you receive;
- be considerate of the rights of other Members, Providers and Our staff;
- read and understand your Certificate and Schedule of Benefits; and
- provide accurate and complete information to Us about other health care coverage and/or insurance benefits you may carry.

3 SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Copayments and other limits when you receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of the Certificate including any attachments or riders.

Pre-Existing Period
Late Enrollee — 18 Months after your Enrollment Date

SECTION 1 Medicare Complementary Benefits

Covered Services	Medicare Part A Pays	Your Copayments, Maximums, Responsibilities
Hospital Care		
First 60 Days of Medicare Benefit Period	Medicare Eligible Expense for Medicare Medically Necessary Hospital care in a semi-private room - EXCEPT for the Medicare Part A Deductible	The Medicare Part A Deductible Covered In Full
61st through 90th day of Medicare Benefit Period	Medicare Eligible Expenses for Medicare Medically Necessary Hospital care in a semi-private room - EXCEPT for the Medicare Part A Coinsurance	The Medicare Part A Coinsurance Covered In Full
91st through 150th day of Medicare Benefit Period	Medicare Eligible Expenses for a Maximum Amount of 60 Lifetime Reserve Days during your lifetime for Medicare Medically Necessary Hospital care in a semi-private room - EXCEPT for the Medicare Part A Coinsurance	The Medicare Part A Coinsurance, upon exhaustion of Lifetime Reserve Days, 10% of Medicare Eligible Expenses, up to an additional 365 days during your lifetime
After 150th day	Nothing	Upon exhaustion of Lifetime Reserve Days, 10% of Medicare Eligible Expenses, up to an additional 365 days during your lifetime

Skilled Nursing Facility Care		
First 20 Days	Medicare Eligible Expense Covered In Full for first 20 days in a semi-private room	
21st Day through 100th Day	Medicare Eligible Expense - EXCEPT for the Medicare Part A Coinsurance	The Medicare Part A Coinsurance Covered In Full
After 100th Day	Nothing	See Section 2 Major Medical benefits for additional coverage
Home Health Care	Medicare Eligible Expense - EXCEPT for the Medicare Part A Coinsurance	The Medicare Part A Coinsurance Covered In Full
Blood	Medicare Eligible Expense - EXCEPT for the first 3 pints of blood	The first 3 pints of blood Covered In Full
Hospice Care	Medicare Eligible Expenses for Medicare Medically Necessary Hospice care - EXCEPT for the Medicare Part A Coinsurance	The Medicare Part A Coinsurance Covered In Full

Covered Services	Medicare Part B Pays	Your Copayments, Maximums, Responsibilities
Physician and Other Outpatient Care	Medicare Eligible Expenses for Medicare Medically Necessary Physician's services and other Outpatient services - EXCEPT for the Medicare Part B Deductible and the Medicare Part B Coinsurance.	The Medicare Part B Deductible and the Medicare Part B Coinsurance Covered In Full.
Outpatient Hospital Care	Medicare Eligible Expenses for Medicare Medically Necessary Outpatient Hospital care eligible under Medicare Part B - EXCEPT for the Medicare Part B Deductible and the Medicare Part B Coinsurance.	The Medicare Part B Deductible and the Medicare Part B Coinsurance Covered In Full.
Medicare Part B Excess Charges on Non-Assigned Claims	Nothing	Covered in Full of the difference between the Medicare Part B billed charge and the Medicare Part B approved charge if the Provider has not accepted Medicare assignment.
Blood	Medicare Eligible Expenses - Except for the first 3 pints of blood and the Medicare Part B Coinsurance.	The first 3 pints of blood and the Medicare Part B Coinsurance Covered In Full.
Outpatient (Non-Hospital) Treatment of Mental Health Conditions	Medicare Eligible Expenses - Except for the Medicare Part B Deductible and the Medicare Part B Coinsurance	The Medicare Part B Deductible and the Medicare Part B Coinsurance Covered In Full.
Outpatient (Non-Hospital) Physical Therapy Including Speech and Occupational Therapy	Medicare Eligible Expenses for certain therapy services - EXCEPT for the Medicare Part B Deductible and the Medicare Part B Coinsurance.	The Medicare Part B Deductible and the Medicare Part B Coinsurance Covered In Full.

SECTION 2 Major Medical Benefits

In addition to the above benefits, Section 2 Major Medical pays for services to the extent they are not paid or payable by Medicare Parts A or B whether or not you have enrolled in Medicare Part B, or under Section 1 Medicare Complementary Benefits. NOTE: Anthem

will use its own standards for determining Medical Necessity and Experimental/Investigative services, not Medicare's, for Covered Services eligible under Section 2 Major Medical Benefits. The Schedule of Benefits is a summary of the Deductibles, Copayments and other limits when you receive Covered Services from a Provider. Please refer to the Covered Services section for a more complete explanation of the specific services covered by the Plan. This Schedule of Benefits lists the Member's responsibility for Covered Services and supplies. Benefits for Covered Services are based on the Maximum Allowable Amount. You are responsible for any balance due between the Provider's charge and the Maximum Allowable Amount in addition to any Compayments, Deductibles, and non-covered charges.

In addition to the services listed below, Covered Services include other Medicare eligible and ineligible services that Anthem determines to be Medically Necessary and not Experimental or Investigational in nature.

Anthem Benefit Period	Calendar Year
Deductible	
Per Person	$100

Note: When a Member incurs covered medical expenses during the last 3 months of a Benefit Period, which are applied against but do not satisfy that year's Deductible, those expenses may be carried over and applied against the Deductible(s) for the next Benefit Period, but not the Out of Pocket. If the Deductible is met, there is no carry-over credit given.

Out-of-Pocket Limit	
Per Person	$600

Note: The Out-of-Pocket Limit includes all Major Medical Deductibles and/or percentage Copayments you incur in an Anthem Benefit Period except for the following services:

- Prescription Drug Benefits

Once the Member and/or family Out-of-Pocket Limit is satisfied, no additional Copayments will be required for the Member and/or family for the remainder of the Anthem Benefit Period except for the services listed above.

Lifetime Maximum for All Other Covered Services	$1,000,000

Covered Services For Major Medical Benefits	**Copayments/Maximums**

Inpatient Services (after 60 lifetime reserve days and additional 365 days have been exhausted under Section 1) Semi-private room: Private Room (average semi-private room rate - if Medically Necessary or if the Hospital has private rooms only.	10%
Ancillary	10%
Skilled Nursing Facility (SNF) after the 100th day Semi-private room; Private room (average semi-private SNF room rate)	20% of the Medicare Eligible Expenses
Outpatient Substance Abuse	20%
Services Received Outside of U.S.A.	Covered In Full of the Maximum Allowable Amount for expenses each calendar year
Home Health Care	20%
Maximum amount payable	$5,000 per calendar year
Home IV Therapy Drugs/Injectable Drugs	20%
Private Duty Nursing/Visting Nurse's Association	20%
Maximum amount payable	$5,000 maximum per calendar year
Accidental Dental	20%

Prescription Drugs

Days Supply:

Days supply may be less than the amount shown due to Prior Authorization, Quantity and/or age limits, and Utilization Guidelines.

Retail Pharmacy (Network and Non-Network)	90 days
Anthem Mail Service Program	90 days
Network Retail Pharmacy Prescription Drug Copayment:	
Generic Drugs	40% Copayment per Prescription Order
Brand Name Drugs	50% Copayment per Prescription Order
Anthem Mail Service Program:	
Generic Drugs	$15 per Prescription Order
Brand Name Drugs	$35 per Prescription Order

Non-Network Retail Pharmacy Prescription Drug Copayment	40% Copayment Generic/50% Copayment Brand/90 Day Supply

Note: Certain Diabetic and Asthmatic supplies are covered when obtained from a Network Pharmacy, subject to prescription drug Copayments. These supplies are not covered if obtained from a Non-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayments .

State Mandated Benefits

These benefits are required to be covered by group health plans in Indiana; they will usually be paid by Medicare and Section 1 Medicare Complementary Benefits.

Mastectomy Reconstruction	Same As Any Other Condition
Diabetes Management	Same As Any Other Condition
Mammography Screening Services	Covered In Full
Prostate Screening	20%, subject to the Deductible; limit one routine prostate screening examination per Member per calendar year
Colorectal Cancer Testing	Covered in Full not subject to the Deductible; limit one routine colorectal cancer examination and related laboratory tests for cancer per Member per calendar year.
Morbid Obesity Treatment Services	20%, subject to the Deductible

*See Covered Services section for any exceptions, limitations, additional detailed descriptions, etc.

4 DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Anthem Benefit Period - The period of time that We pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Brand Name Drug - The initial version of a medication developed by a pharmaceutical manufacturer, or a version marketed under a

pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires, if FDA requirements are met any manufacturer can produce the drug and sell under its own brand name, or under the drug's chemical name (Generic).

Certificate - This summary of the terms of your benefits. It is attached to and is a part of the Group Contract and is subject to the terms of the Group Contract.

Copayment - A specific dollar amount or percentage of Maximum Allowable Amount indicated in the Schedule of Benefits for which you are responsible for Covered Services. The Copayment does not apply towards any Deductible.

Covered Services - Services, supplies or treatment as described in this Certificate which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Certificate.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under this Certificate is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Certificate, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Certificate.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you.

Custodial Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. **Anthem will determine whether services are Custodial Care and are not Medically Necessary under Section 2 Major Medical benefits**. Custodial care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Deductible - The dollar amount of Covered Services listed in the Schedule of Benefits for which you are responsible before We start to pay for Covered Services subject to the Deductible each Benefit Period.

Dependent - Your eligible Dependent, as described in the **Eligibility and Enrollment** section.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition or a test performed as a Medically Necessary preventive care screening for an asymptomatic patient. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care - Care provided in a residential institution, treatment center, halfway

house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date - The date when your coverage begins under this Certificate.

Eligible Person - A person who satisfies the Group's eligibility requirements and is entitled to apply to be a Subscriber.

Enrollment Date - The first day of coverage or, if there is a waiting period, the first day of the waiting period.

Expedited Review - The expedited handling of a Grievance or Appeal concerning Our denial of certification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-Expedited Review could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative - Anthem will determine whether services eligible for payment under Section 2 Major Medical benefits are Experimental/Investigative. Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative. We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one of more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by Us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under Section 2 Major Medical benefits.

External Grievance - Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Certificate.

Generic Drugs - Drugs which have been determined by the FDA to be bioequivalent to Brand Name Drugs and are not manufactured or marketed under a registered trade name or trademark. A drug whose active ingredients duplicate those of a Brand Name Drug and is its bioequivalent, Generic Drugs must meet the same FDA specifications for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart Brand Name Drug. On average, Generic Drugs cost about half as much as the counterpart Brand Name Drug.

Grievance - Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or Medically Necessary;
- a determination that a proposed service is Experimental or Investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan or the Group and the Plan.

Group - The employer, association, trust, or other entity that has entered into a Group Contract with the Plan.

Group Contract (or Contract) - The Contract between the Plan and the Group. It includes this Certificate, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Identification Card - A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient - A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Lifetime Maximum - The maximum dollar amount We will pay for Covered Services during your lifetime. This is applicable to all Major Medical Covered Services.

Mail Service - A prescription drug program which offers a convenient means of obtaining maintenance medications by mail if the Subscriber takes prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed Pharmacy Mail Service who has entered into a reimbursement agreement with Us, and sent directly to the Subscriber's home.

Maximum Allowable Amount - The amount that We, or Our Subcontractor, determine is the maximum amount payable for Covered Services you receive, up to but not to exceed charges actually billed. Generally, to determine the Maximum Allowable Amount for a Covered Service, We or Our Subcontractor use internally developed criteria and industry accepted methodologies and fee schedules which are based on estimates of resources and costs required to provide a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

For a Provider who has a participation agreement with Us, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under any participation agreement with Us. If a Provider accepts as full payment an amount less than the negotiated rate under a participation agreement, the lesser amount will be the Maximum Allowable Amount.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its agreement with Us.

Medically Necessary or Medical Necessity - Anthem will determine whether services eligible for payment under Section 2 Major Medical benefits are Medically Necessary. An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by Us to be:

1. Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
2. Obtained from a Provider;
3. Provided in accordance with applicable medical and/or professional standards;
4. Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
5. The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
6. Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost);
7. Not Experimental/Investigative;
8. Not primarily for the convenience of the Member, the Member's family or the Provider.
9. Not otherwise subject to an exclusion under this Certificate.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary. Anthem will determine whether services eligible for payment under Section 2 Major Medical benefits are Medically Necessary.

Medicare - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Medicare Benefit Period - The period of time used by Medicare to measure your coverage under Medicare Part A. Your first Benefit Period begins on the day you enter a Hospital as a Medicare patient. It ends 60 days after you leave the Hospital (counting the day of your discharge) or, if you have to go from the Hospital to a Skilled Nursing Facility, it ends 60 days after you leave the Skilled Nursing Facility. If you are hospitalized again within 60 days, the second Hospital stay is considered part of the first Benefit Period.

Medicare Coinsurance - That portion of the health care charges that you are required to pay for under Medicare after the applicable Medicare Deductible is met.

Medicare Eligible Expenses - Expenses of the kinds covered by Medicare, to the extent recognized as reasonable and Medically Necessary by Medicare.

Medicare Medically Necessary - Services and supplies that Medicare determines are necessary for the treatment of illness or injury. **Anthem will determine whether services eligible for payment under Section 2 Major Medical benefits are Medically Necessary.**

Medicare Part A or Part B Deductible - The amount of health care charges Medicare requires you to pay before Medicare Part A or Part B benefits are paid.

Medicare Part B Excess Charges - The difference between the actual Medicare Part B billed charge and the Medicare approved Part B charge for non-assigned claims. The billed charges must not exceed any limitation established by Medicare or state law.

Member - A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

New FDA Approved Drug Product or Technology - The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Out of Pocket Limit (Major Medical Section Benefits only) - A specified dollar amount of expense incurred by a Member and/or Dependent for Covered Services in a Benefit Period as listed on the Schedule of Benefits. When the Out of Pocket Limit is reached for a Member and/or Dependent, then no additional Deductibles and Copayments are required for that person and/or Dependent unless otherwise specified in this Certificate and/or the Schedule of Benefits.

Outpatient - A Member who receives services or supplies while not an Inpatient.

Pharmacy and Therapeutics Committee - A committee of Physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The

committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Plan (We, Us, Our) - Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Certificate.

Pre-Existing Condition - A condition (mental or physical) which was present and for which medical advice, diagnosis, care or treatment was recommended or received within the 3 Months period ending on your Enrollment Date. Pregnancy is not considered a Pre-Existing Condition. Genetic information may not be used as a condition in the absence of a diagnosis.

Premium - The periodic charges which the Member or the Group must pay the Plan to maintain coverage.

Prescription Legend Drug - A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under this Certificate.

Prescription Order - A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Prior Authorization - The process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider - A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities:

- **Ambulatory Surgical Facility** - A Provider that:

  1. is licensed as such, where required;
  2. is equipped mainly to do Surgery;
  3. has the services of a Physician and a Registered Nurse (R.N.) at all times when a patient is present;
  4. is not an office maintained by a Physician for the general practice of medicine or dentistry; and
  5. is equipped and ready to initiate emergency procedures with personnel who are certified in Advanced Cardiac Lifesaving Skills.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a Certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a precertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

1. provides room and board and nursing care for its patients;
2. has a staff with one or more Physicians available at all times;
3. provides 24 hour nursing service;
4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

- 1. nursing care;
  2. rest care;
  3. convalescent care;
  4. care of the aged;
  5. Custodial Care;
  6. educational care;
  7. treatment of alcohol abuse; or
  8. treatment of drug abuse.

- **Pharmacy** - An establishment licensed to dispense prescription drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physician** -

  1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
  2. any other legally licensed practitioner of the healing arts rendering services which are:
     a. covered by the Plan;
     b. required by law to be covered when rendered by such practitioner; and
     c. within the scope of his or her license.

  Physician does not include:

  1. the Member; or
  2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:

  1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
  2. provides care supervised by a Physician;
  3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
  4. is not a place primarily for care of the aged, Custodial Care or Domiciliary Care, or treatment of alcohol or drug dependency; and
  5. is not a rest, educational, or Custodial Provider or similar place.

- **Urgent Care Center** - A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery - A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Single Coverage - Coverage for the Subscriber only.

Skilled Care - Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and

usually involves a treatment plan. **Anthem will determine whether services are Skilled Care and are Medically Necessary under Section 2 Major Medical benefits.**

Subcontractor - Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs and mental health/behavioral health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber - An eligible retired employee or Member of the Group whose coverage is in effect and whose name appears on the Identification Card issued by Us.

5 ELIGIBILITY AND ENROLLMENT

Coverage provided under this Certificate is made available to you because of your retirement from the Group or membership in the Group.

In order for you to participate in the Group's benefit plan, certain requirements must be satisfied. These requirements may include probationary or waiting periods. The specific time periods and other standards for participation in the Group's benefit plan are determined by the Group, or state and/or federal law, and approved by Us. Eligibility requirements are described in general terms below.

For more specific eligibility information you should see your Human Resources or benefits department or the Group.

Eligibility

Unless We and the Group agree otherwise and notify you accordingly, the following eligibility rules apply:

Subscriber

To be eligible to enroll as a Subscriber, you must:

1. be retired or be the spouse of a retiree from the Group;
2. be age 65 or older;
3. be enrolled under Parts A and B of Medicare;
4. have not enrolled in a Medicare + Choice Plan, and do not have any Medicare Supplement coverage.

Dependents

To be eligible for Coverage to enroll as a Dependent, you must:

1. be listed on the enrollment form completed by the Subscriber,
2. meet all Dependent eligibility criteria established by the Group, and
3. be enrolled under Parts A and B of Medicare.

Enrollment

The Subscriber shall furnish to Anthem such notification and other information as may be required by Anthem for the purpose of enrolling Members, processing terminations, effecting changes in single or family contract status, determining the amount payable by the Member under this Contract, or for any other purpose reasonably related to the administration of this Certificate.

Anthem reserves the right to limit retroactive changes to enrollment to a maximum of sixty (60) days from the date notice is received. Acceptance of payments from the Member or the payment of benefits to persons no longer eligible will not obligate Anthem to provide benefits.

Initial Enrollment

During the initial Enrollment period, eligible retired Subscribers of the Group shall be entitled to apply for coverage for themselves and their eligible Dependent, who are listed on the enrollment form provided by Us.

Newly Eligible Persons

Any person who becomes newly eligible after the initial Enrollment period (e.g., new Dependent, or newly retired Subscriber), is eligible for coverage effective on the first date eligible only if all of the following conditions are met:

- The enrollment form must be received by the Plan within thirty-one (31) days of becoming eligible; and
- Timely payment of the applicable enrollment fees.

Special Enrollment

A Special Enrollment period may occur if an Eligible Person or Dependent with other health coverage declined coverage under this Plan and then loses their other coverage, or if an Eligible Person or Subscriber gains a Dependent through marriage. If an Eligible Person or Dependent enrolls during a Special Enrollment period even if it is at the same time as an open enrollment period that person will not be treated as a Late Enrollee.

Special Enrollment for Loss of Other Coverage

The Special Enrollment period for loss of other coverage is available to Eligible Persons and their Dependents who meet certain requirements:

- the Eligible Person and/or their Dependent must otherwise be eligible for coverage;
- when coverage under this Plan was declined, the Eligible Person or their Dependent must have been covered under another group plan or must have had other health insurance coverage, and enrollment must have been declined in writing on Our enrollment form application.

The rights under this Special Enrollment period may apply with respect to:

- an Eligible Person;
- a Dependent of an Eligible Person; or
- both.

An Eligible Person who has not previously enrolled may enroll during the Special Enrollment period if they have lost their other coverage. A Dependent of a Subscriber may enroll during the Special Enrollment period if the Dependent lost their other coverage and the Subscriber is currently enrolled in this Plan. In addition, both the Eligible Person and a Dependent can enroll together if either the Eligible Person or the Dependent loses other coverage.

If the other coverage is COBRA continuation coverage, then Special Enrollment can only be requested after the COBRA continuation coverage has exhausted. If the other coverage is not COBRA continuation coverage, then Special Enrollment for the Eligible Person or Dependent can only be requested after one of the following has occurred:

- eligibility for the other coverage was lost; or
- employer contributions for the other coverage has ended.

Special Enrollment is not available if the other coverage is lost due to failure to pay premium or for fraud or misrepresentation.

Request for Special Enrollment must be made within 31 days of the loss of other coverage. Coverage under Special Enrollment will be effective no later than the first day of the month after the Eligible Person requests enrollment for himself or herself, or a Subscriber requests enrollment on behalf of a Dependent.

Special Enrollment for New Dependents

A Special Enrollment period also occurs if an Eligible Person or a Subscriber acquires a new Dependent by marriage. The request to enroll must be made within 31 days following the qualifying event.

- An Eligible Person who has previously declined to enroll is permitted to enroll themselves and their Dependents when they marry.
- A Subscriber may enroll their spouse separately at the time of marriage.

Special Enrollment period coverage with respect to marriage will be effective on the date of marriage if We receive an application within 31 days of that qualifying event.

If We receive an application to add a Subscriber's Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, that person is only eligible for coverage during the Open Enrollment period. Application forms are available from the Plan.

Portability

Any Pre-Existing Condition waiting period will be reduced by the aggregate of the periods of prior creditable coverage applicable to you as of your Enrollment Date under this Plan. Creditable coverage is prior coverage you had from: a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, public health plan, Peace Corps service, or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan. You have the opportunity to prove that you have prior creditable coverage and We will assist you in obtaining that information if required.

Continuous Coverage

If you were covered by the Group's prior carrier or plan immedicately prior to the Group's enrollment with Anthem Blue Cross Blue Shield, with no break in coverage, then you will receive credit for any accrued Deductible and, if applicable, Out of Pocket amounts under that other plan. This does not apply to persons who were not covered by the prior carrier or plan on the day before the Group's coverage with Anthem began, or to persons who join the Group later.

If your Group moves from one Anthem Blue Cross Blue Shield plan to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately prior to enrolling in this product with no break in coverage, then any maximums, including Lifetime Maximums, when applicable, will be carried over and charged against the maximums and/or Lifetime Maximum under this certificate.

If your Group offers more than one Anthem product, and you change from one Anthem product to another with no break in coverage, you will receive credit for any accrued Deductible and, it applicable, Out of Pocket amounts and any Lifetime Maximum will be carried over and charged agains the Lifetime Maximum.

If your Group offeres coverage through other products or carriers in addition to Anthem's, and you change products or carriers to enroll in this Anthem product with no break in coverage, you will receive credit for any accrued Deductible, Out of Pocket, and Lifetime Maximum amounts.

THIS SECTION DOES NOT APPLY TO YOU IF YOU:

- Change from an individual Anthem Blue Cross Blue Shield policy to a group Anthem Blue Cross Blue Shield plan;
- Change employers and both have Anthem Blue Cross Blue Shield coverage; or
- Are a new Member of the Group who joins the Group after the Group's initial enrollment with Anthem. Such new Members will receive credit from their prior carrier as described in the Portability section.

Delivery of Documents

We will provide a Plan Identification Card for each Member and a Certificate for each Subscriber.

Notice of Ineligibility

You must notify Us of any changes which will affect your Dependent's eligibility for services or benefits under this Certificate.

Notice of Changes

The Subscriber is responsible to notify the Group of any changes which will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Plan must be notified of any changes as soon as possible but not later than within 31 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status, enrollment or disenrollment in another health plan. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of payments from the Group for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 31 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage.

All notifications by the Group must be in writing and on approved forms. Such notifications must include all information reasonably required to effect the necessary changes.

A Member's coverage terminates on the date such Member ceases to be in a class of Members eligible for coverage. The Plan has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.

Effective Date Of Coverage

For information on your specific Effective Date of coverage under this Certificate, you should see your Human Resources or benefits department or the Group or contact Us.

6 TERMINATION, CONTINUATION, CONVERSION

Termination

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual effective date of termination may vary based on your Group's agreement with Us and your specific circumstances, such as whether premium has been paid in full:

- If you terminate your coverage, termination will generally be effective on the last day of the billing period in which We received your notice of termination.
- Subject to any applicable continuation requirements, if you cease to meet eligibility requirements as outlined in this Certificate, your coverage generally will terminate on the last day of the billing period. The Group and/or you must notify Us immediately if you cease to meet the eligibility requirements. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan or under any other non-Anthem plan which is offered by, through or in connection with the Group as an option instead of this Plan, then coverage for you and your Dependent will generally terminate at the end of the billing period for which premium has been paid, subject to the consent of the Group. The Group agrees

to immediately notify Us that you have elected coverage elsewhere.

- A Dependent's coverage will generally terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.

- If coverage is through an association, coverage will generally terminate on the date membership in the association ends.

- If you engage in fraudulent conduct or furnish Us fraudulent or misleading material information relating to claims or application for coverage, then We may terminate your coverage. Termination is generally effective 31 days after Our notice of termination is mailed. You are responsible to pay Us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Premium paid for such services. We will also temrinate your Dependent's coverage, generally effective on the date your coverage was terminated. We will notify the Group in the event We terminate your and your Dependent's coverage.

- If you fail to pay or fail to make satisfactory arrangements to pay any amount due to Us or Providers (including the failure to pay required Deductibles and/or Copayments), We may terminate your coverage and may also terminate the coverage of all your Dependents, generally effective immediately upon Our written notice to the Group.

- If you permit the use of yours or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice to the Group. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for the Maximum Allowable Amount for services received through such misuse.

- You will give Anthem at least five (5), working days advance notice of any Subscriber's termination from the Group, in order to enable Anthem to remove the Subscriber and/or his Dependents from Anthem's list of Members. Further, if Anthem has provided benefits for persons no longer eligible because Anthem did not receive timely notification of termination, then you shall reimburse Anthem for all unrecovered claim amounts paid.

- In the event that a Member is no longer eligible for coverage and has been terminated from the coverage, and after the effective date of termination Anthem (or its subcontracted vendors) makes payment of any claims which would otherwise have been payable under the terms of this Certificate but for the fact that the claims were icurred after the effective date of termination, the Member shall be liable to reimburse Anthem for all unrecovered claim amounts paid.

- If a Member dies while this Certificate is in Force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or the estate when notice of the death is provided within 12 months of the date of death.

No coverage shall be in force and no benefit shall be payable for charges which are incurred after the date a Subscriber's coverage terminates for any reason under this Plan, except as provided by COBRA.

Misstatement of Age

The Group and/or Subscriber is liable to the Plan for the full difference between what was paid for coverage rated on an incorrect statement of age and what is owed for coverage given the correct age.

Reinstatement

You will not be reinstated automatically if coverage is terminated. Re-application is necessary, unless termination resulted from inadvertent clerical error. No additions or terminations of membership will be processed during the time your or the Group's request for reinstatement is being considered by Us. Your coverage shall not be adversely affected due to the Group's clerical error. However, the Group is liable to Us if We incur financial loss as a result of Group's clerical error.

Federal Continuation of Coverage (COBRA)

The provisions described below for COBRA continuation coverage shall also apply to Domestic Partners and their children when covered under this Certificate as Dependents. Termination of a Domestic Partnership or ceasing to be a Dependent will be considered Qualifying Events.

If you are covered under a Group which is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 as amended, the Plan provides that each of the qualified beneficiaries listed below has the right to choose continuation coverage if his or her coverage under the Certificate would otherwise end. The election period lasts for 60 days and begins to run on the later of :

1. the date that you would lose coverage due to the qualifying event; or
2. the date you are sent notice of your right to continuation coverage.

Unless the election specifies otherwise, an election by a covered Subscriber or a spouse is also considered an election on behalf of any other qualified beneficiary who would also lose coverage due to that qualifying event.

Election Period for Workers who are Receiving Trade Adjustment Assistance

An additional COBRA election period is available for certain eligible workers who have not already elected COBRA. This second election period applies to individuals who have petitions on file requesting certification for trade adjustment assistance under the 1974 Trade Act on or after November 4, 2002.

You are eligible to elect COBRA during this second election period if you:

1. are receiving trade adjustment assistance, as demonstrated by appropriate government certification;
2. lost group health plan coverage due to a job loss that resulted in eligibility for trade adjustment assistance; and
3. failed to elect COBRA during the regular COBRA election period that was triggered by that job loss.

This second 60-day COBRA election period begins on the first day of the month in which you are determined to be eligible for trade adjustment assistance, but no election may be made later than six months after the initial loss of group health plan coverage.

Any COBRA coverage elected through this second election period will begin with the first day of the second election period, and not on the date on which you first lost group coverage. However, the time between the initial loss of coverage and the start of the second election period will not count in determining if there is a 63-day break in coverage for purposes of HIPAA.

Qualifying Events and Qualified Beneficiaries

The following qualified beneficiaries (not including nonresident aliens who received no income constituting earned income under federal law from the employer and the nonresident aliens' Dependents) have the right to continuation coverage when one of the following qualifying events results in a loss of coverage under the contract:

1. Upon the death of the covered Subscriber: the spouse and Dependent children.

2. Upon the covered Subscriber's termination (for other than gross misconduct) or reduction in work hours: the Subscriber and his or her eligible Dependents.

3. Upon the divorce or legal separation of the covered Subscriber: the divorced or legally separated spouse and Dependent children.

4. Upon the covered Subscriber becoming enrolled in Medicare under Title XVIII of the Social Security Act: the spouse and Dependent children.

5. Upon the disqualification of a Dependent child under the Certificate's eligibility requirements: the Dependent child not meeting such requirements.

6. Upon the Group's filing of a Title XI Bankruptcy: the retired covered Subscriber and his or her Dependents who

    a. as a result of the bankruptcy filing would experience a substantial elimination of health coverage, under the Certificate, within a year of the bankruptcy filing; or

    b. has experienced an elimination of coverage during the year preceding the bankruptcy filing.

For the purposes of this section, coverage for a Dependent child includes coverage for any child born to or placed for adoption with a qualified beneficiary after a qualifying event if proper notice is provided to the Group of the birth or adoption.

If you have already enrolled in Medicare before the time of your qualifying event, you may still elect COBRA coverage. If you enroll in Medicare after you have already elected COBRA coverage, then your COBRA coverage will terminate as stated below in number 4, Cancellation.

If a Spouse or Dependent Child of a Subscriber is covered through a Subscriber by alternative coverage, and the right to receive the alternative coverage will cease upon the death of or divorce or legal separation from the Subscriber, the end of the alternative coverage shall be considered a qualifying event as described in 1. and 3. above, regardless of whether the alternative coverage would satisfy COBRA continuation coverage rules. "Alternative coverage" means coverage provided by an Employer without regard to COBRA continuation coverage, as a result of: state or local law; industry practice; a collective bargaining or severance agreement; plan procedure; or disability or workers compensation leave.

Duration of Continuation Coverage

1. For the events explained in paragraphs "1," "3," "4," and "5" under "Qualifying Events and Qualified Beneficiaries," continuation coverage is provided for 36 months after the date of the initial qualifying event.

2. For the event explained in paragraph "2" under "Qualifying Events and Qualified Beneficiaries," continuation coverage is provided for 18 months after the date of the qualifying event. Exceptions:

    a. If the qualifying event under paragraphs "1," "3," "4," and "5" above occursduring the 18-month period, continuation coverage will be continued an additional 18 months; or

    b. If a qualified beneficiary is determined under Titles II or XVI of the Social Security Act to be disabled at any time prior to or during the first 60 days of continuation coverage under paragraph "2," under "Qualifying Events and Qualified Beneficiaries," continuation coverage will be extended an additional 11 months.

    However, coverage will be extended only if the qualified beneficiary gives notice of the disability within 60 days after the disability is determined and before the end of the original 18-month continuation period. When the qualified beneficiary is no longer disabled, he or she must notify the employer within 30 days after the final

determination is made under Titles II and XVI.

c. If the Subscriber became enrolled in Medicare prior to the qualifying event, the period of coverage for qualified beneficiaries other than the Subscriber shall be the longer of 18 months from the termination or reduction in hours of employment or 36 months from the earlier Medicare entitlement.

3. For the event explained in paragraph "6" above, continuation coverage is provided until the death of the retired covered Subscriber. If the covered Subscriber dies before the occurrence of the qualifying event, continuation coverage is provided until the death of the surviving spouse. Upon the death of the covered Subscriber, his or her Dependents (other than a surviving spouse entitled to lifetime coverage) are entitled to continuation coverage as explained in paragraph "1" of the preceding section.

The maximum period for all qualifying events is 36 months, except as may occur under paragraphs "3" immediately above.

Premiums

You must pay premiums for any period of continuation coverage. If you make the election after the qualifying event, any premiums due must be paid by 45 days after the date of the election.

Cancellation

Continuation coverage will terminate if:

1. the Group ceases to provide any group health Plan to its Subscribers;

2. premiums are not paid on time;

3. upon the date, after the date of continuation coverage election, the qualified beneficiary first becomes covered under another group health plan that:

   a. does not contain any limitation regarding a pre-existing condition of the beneficiary; or

   b. does contain a pre-existing exclusion or limitation that would apply to the beneficiary but is not applicable because of the Federal Health Insurance Portability and Accountability Act of 1996's rule on pre-existing condition clauses;

4. upon the date, after the date of continuation coverage election, a qualified beneficiary other than beneficiaries that are provided continuation of coverage under paragraph "6," under "Qualifying Events and Qualified Beneficiaries," first becomes enrolled in Medicare benefits under Title XVIII of the Social Security Act; or

5. a qualified beneficiary who was disabled under paragraph "2," under "Qualifying Events and Qualified Beneficiaries," is no longer disabled. The additional 11 months of extended continuation coverage will be terminated on the first day of the month that begins more than 30 days after the date of the final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled.

7 HOW TO OBTAIN COVERED SERVICES

Benefits are provided when you obtain Covered Service from Providers. We may inform you for Section 2 Major Medical benefits that it is not Medically Necessary for you to receive services from a Provider or remain in a Hospital or other Facility. This decision is made upon review of your condition and treatment and Medicare's or Our determination of Medical Necessity. You may appeal this decision. See Complaint and Appeals Procedures in the General Provisions section of

this Certificate.

Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Certificate does not give anyone any claim, right, or cause of action against the Plan based on what a Provider of health care, services or supplies, does or does not do.

Identification Card

When you receive care from a Provider, you must show your Identification Card. Possession of an Identification Card confers no right to services or other benefits under this Certificate. To be entitled to such services or benefits you must be a Member on whose behalf all applicable Premiums under this Certificate have been paid. If you receive services or other benefits to which you are not then entitled under the provisions of this Certificate you will be responsible for the actual cost of such services or benefits.

8 HEALTH CARE MANAGEMENT

Health Care Management is applicable for Section 2 Major Medical benefits.

Health Care Management is included in your health care beneits to encourage you to seek quality medical care on the most cost-effective and appropriate basis.

Health Care Management is a process designed to promote the delivery of cost-effective medical care to all Members by reviewing the use of appropriate procedures, setting (place of service), and resources through Case Management.

Your rights to benefits for Covered Services provided under this Certificate is subject to certain policies, guidelines, and limitations, including, but not limited to, Our clinical coverage guidelines, Medical Policy and Health Care Management feature listed in this section.

A description of the Health Care Management feature, its purpose, requirements and effects on benefits is provided in this section.

Case Management (includes Discharge Planning)

Case Management is a Health Care Management feature designed to promote the most appropriate and cost effective care setting. This feature allows Us to customize your benefits by approving otherwise non-Covered Services or arranging an earlier discharge from an Inpatient setting for a patient whose care could be safely rendered in an alternate care setting. That alternate care setting or customized service will be covered only when arranged and approved in advance by Our Health Care Management staff. In managing your care, We have the right to authorize substitution of Outpatient Services or services in your home to the extent that benefits are still available for Inpatient Services.

Clinical Coverage Guidelines

Our clinical coverage guidelines, such as medical policy, and preventive care clinical guidelines, reflect the standards of practice and medical interventions identified as reflecting appropriate medical practice. The purpose of Clinical Coverage Guidelines is to assist in the interpretation of Medical Necessity. However, the Certificate and Group Contract take precedence over the clinical coverage guidelines. Medical technology and standards of care are constantly changing and We reserve the right to review and update the clinical coverage guidelines periodically.

9 COVERED SERVICES

SECTION 1 - MEDICARE COMPLEMENTARY BENEFITS

This section describes the benefits available when Medicare has made payment for a Medicare Eligible Expense. We will cover the amount Medicare determines is your liability for Medicare Eligible Expenses.

The amounts We pay and the benefits covered are as follows:

MEDICARE PART A

Medicare Part A Deductible

Medicare Part A requires you to pay a Deductible each Medicare Benefit Period before it pays for Hospital expenses. See your Schedule of Benefits for coverage of the Part A Deductible and any benefit limitations.

Hospital Inpatient Services

Medicare Part A requires you to pay certain Medicare Coinsurance amounts during your Hospital stay beginning on the 61st day and ending after the 90th day in any Medicare Benefit Period. We will pay the Medicare Coinsurance. See your Schedule of Benefits for any benefit limitations.

Medicare Part A requires you to pay certain Medicare Coinsurance amounts during your Hospital stay during the use of Medicare's sixty lifetime reserve days. We will pay the Medicare Coinsurance. See your Schedule of Benefits for any benefit limitations.

If you exhaust Your Medicare Part A Hospital benefits (including your reserve lifetime days), after the 90th day We will pay the Medicare Eligible Expenses up to the Plan maximum of an additional 365 days. See your Schedule of Benefits for any benefit limitations.

Skilled Nursing Facility Services

Medicare Part A pays for Medicare Eligible Expenses you receive in a Skilled Nursing Facility in full for the first 20 days in a semi-private room. We will pay the Medicare Part A Coinsurance from the 21st through the 100th day in a Skilled Nursing Facility care. **NOTE: See Major Medical Benefits in this booklet for Skilled Nursing Facility Services after the 100th day.**

Home Health Care

We will pay the Medicare Coinsurance. See your Schedule of Benefits for any benefit limitations.

Medicare Part A Blood

We will pay for the first three pints of blood Medicare requires you to pay. See your Schedule of Benefits for any benefit limitations.

Hospice Care

We will pay the Medicare Coinsurance for Outpatient drugs while in a Hospice and Inpatient respite care (care given to a Hospice patient so that the usual caregiver can rest). See your Schedule of Benefits for any benefit limitations.

MEDICARE PART B

Medicare Part B Deductible

Medicare Part B requires you to pay a Deductible each calendar year before it pays for Physician or other Provider services. See your Schedule of Benefits for coverage of the Part B Deductible and any benefit limitations.

Medical Services

Medicare Part B covers services you receive from Physicians and other Medicare approved Providers. These include independent laboratories, ambulance services, and independent physical therapists. Some Hospital services are also covered under Part B.

Medicare Part B requires you to pay certain Medicare Coinsurance amounts for Part B Eligible Expenses. We will pay the Medicare Coinsurance. See your Schedule of Benefits for any benefit limitations.

Medicare Part B Excess Charges (non-assigned claims only)

Coverage for the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge. See your Schedule of Benefits for any benefit limitations.

Medicare Part B Blood

We will pay for the first 3 pints of blood Medicare requires you to pay and the Medicare Coinsurance. See your Schedule of Benefits for any benefit limitations.

Outpatient (non-Hospital) Treatment of Mental Health Conditions

We will pay the Medicare Coinsurance. See your Schedule of Benefits for any benefit limitations.

Outpatient (non-Hospital) Physical Therapy including Speech and Occupational Therapy

We will pay the Medicare Coinsurance. See your Schedule of Benefits for benefit limitations.

SECTION 2- MAJOR MEDICAL BENEFITS

This section describes the additional Covered Services available under your health care benefits when provided and billed by eligible Providers. **We will not pay benefits under Section 2 Major Medical for services paid or payable by Medicare or by Us as described above or in the Schedule of Benefits for Section 1 Medicare Complementary benefits.**

You are responsible for any balance due between the Provider's charge and the Maximum Allowable Amount in addition to any Copayments, Deductibles, and non-covered charges.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Certificate, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Certificate, including, use of Participating Providers, and obtain any required Prior Authorization. Contact your Participating Provider to be sure that Prior Authorization has been obtained. We base Our decisions about Prior Authorization, Medical Necessity, Experimental/Investigative services and new technology on Our Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Certificate. Benefits for Covered Services are based on the Maximum

Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Copayment, Deductible, Benefit Period maximum, or Lifetime Maximum in this Certificate.

NOTE: Anthem will use its own standards for determining Medical Necessity and Experimental/Investigative services, not Medicare's, for Covered Services eligible under Section 2 Major Medical Benefits.

In addition to the services listed below, Covered Services include other Medicare eligible and ineligible services that Anthem determines to be Medically Necessary and not Experimental or Investigational in nature.

Inpatient Services

Inpatient Services do not include care related to Mental Health Conditions, except as specified. Inpatient Services include:

- charges from a Hospital or other Provider for room, board and general nursing services;
- ancillary services; and
- professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- a room with two or more beds;
- a private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you occupy a private room for isolation and no isolation facilities are available.
- a room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary Services

- operating and treatment rooms and equipment;
- prescribed drugs;
- anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider;
- medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services; and
- Therapy Services.

Professional Services

- **Medical care visits** limited to one visit per day by any one Physician.
- **Intensive medical care for** constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules are excluded.
- **Surgery and the administration of general anesthesia**.

Skilled Nursing Facility (SNF)

Room and Board

Benefits begin on the 101st day. Covered rooms are semi-private and private. See your Schedule of Benefits for benefit limitations.

Ancillary

Covered charges for SNF ancillaries, including Diagnostic Services.

NOTE: After Medicare's benefits are exhausted, the Plan's Medical Policy Committee must review Skilled Nursing Facility services to determine whether they meet the Plan's Skilled Care guidelines.

Ambulance Services

Local transportation by a vehicle designed, equipped and used only to transport the sick and injured:

- From your home, scene of accident or medical emergency to a Hospital;
- Between Hospitals;
- Between Hospital and Skilled Nursing Facility
- From a Hospital or Skilled Nursing Facility to your home.

Ambulance services are a Covered Service only when Medically Necessary, except: When ordered by an employer, school, fire, or public safety official and the Member is not in a position to refuse.

Trips must be to the closest local facility that can give Covered Services appropriate for your condition. If none, you are covered for trips to the closest such facility outside your local area.

Substance Abuse

Outpatient Facility Services and Physician Office Services for the treatment for Substance Abuse are covered for the diagnosis, crisis intervention and short term treatment for detoxification and/or rehabilitation of Substance Abuse. Copayments are specified in the Schedule of Benefits.

Medically Necessary Services In A Foreign Country

Benefits paid for treatment provided outside the United States, if the treatment received meets all but the geographical requirement for payment of Medicare benefits. See your Schedule of Benefits for benefit limitations. This benefit does not apply to home health care.

Travel outside the country:

- Go to the nearest health care facility.
- Call your Physician or Us within 48 hours.
- Once your care is completed, you will need to pay the bill. (You may want to use a credit card. The credit card company will automatically transfer the foreign currency into American dollars for you.) **Keep all your receipts!**
- When you return home, call Us at the number on the back of your ID card or stop by your Group's personnel office contact the Group or Us and ask for a claim form.
- Fill out the claim form and submit it with your receipts to Our address on the form. (The amount submitted must be in American dollars.)
- You will be reimbursed based on the benefits of your Plan.

Home IV Therapy Drugs/Injectable Drugs

Covered Services are Injectable drugs when ordered by a Physician, intravenous antibiotic therapy, total parenteral nutrition, enteral nutrition (when only source of nutrition), hydration therapy, solutions, additives, and intravenous pain management. Services must be provided by a retail pharmacist, a licensed medical supply company, or a home health care Provider. A Physician's prescription must be included for each drug to be covered.

Private Duty Nursing

Covered Services are for non-custodial nursing care by a RN or LPN, when you have been referred by a Physician.

Visiting Nurse's Association

Covered Services are for direct patient care in the home, including:

- Health supervision;
- Education; and
- Counseling.

Services performed by RNs, LPNs, and other personnel such as home health aides, dieticians, and therapists are covered.

Dental Services

Related to Accidental Injury

Outpatient Facility Services, Physician Office Services, Emergency Care Services, and Urgent Care Services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/maxillary reconstruction;
- Anesthesia.

Non-Covered Services for accidental dental include, but are not limited to:

- Charges for any Investigational/Experimental treatment, procedure, facility, equipment, drug, device or supply;
- Surgery or treatments to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin), except for reconstructive services performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process.

Dental Care

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member who is physically or mentally disabled, are covered if the Member requires dental treatment to be rendered in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, are the utilization standards for determining whether performing dental procedures necessary to treat the Member's condition under general anesthesia constitutes appropriate treatment. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

Prescription Drugs

Anthem Prescription Management

The pharmacy benefits available to you under this Certificate are managed by our affiliate, Anthem Prescription Management (APM). APM is a pharmacy benefits management company with which We contract to manage your pharmacy benefits. APM has a nationwide network of retail pharmacies, and a Mail Service pharmacy

The management and other services APM provides include, among others, managing a network of retail pharmacies and operating a Mail Service pharmacy. APM, in consultation with Us, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; proper dosage; drug interactions or drug/pregnancy concerns.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before APM and/or the Plan can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs. Covered Services will be limited based on Medical Necessity, quantity and/or age limits established by the Plan, or utilization guidelines. Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular drug).

Covered Prescription Drug Benefits

Covered Services include only:

- Prescription Legend Drugs only;
- Any other drug under applicable state law which may only be dispensed upon the written prescription of a physician or other lawful prescriber;
- DESI drugs;
- Injectable insulin and syringes used for administration of insulin;
- Injectables;
- Drugs dispensed by a Physician;
- Medication administered by a skilled nursing facility which operates a pharmaceutical dispensing facility;
- Certain supplies and equipment (such as those for diabetes and asthma) are covered. Contact Us to determine approved covered supplies.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical foods means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

Non Covered Prescription Drug Benefits (please also see the Exclusions section of this Certificate for other non Covered Services)

- Fertility drugs;
- Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any drugs or products that are therapeutically comparable to an over the counter drug, device, or product;
- Off label use, except as otherwise prohibited by law or as approved by Us or APM;
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order;
- Charges for the administration of any drug;
- Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to drugs used in conjunction with a Diagnostic Service or with Chemotherapy performed in the office; they are Covered Services;

- Any drug which is primarily for weight loss, except certain drugs for the treatment of morbid obesity may be Covered Services based on Medical Necessity;
- Drugs not requiring a prescription by federal law except for injectable insulin and state-controlled drugs;
- Drugs in quantities which exceed the limits established by the Plan, or which exceed any age limits established by Us;
- Any drug which is primarily for cosmetic purposes (including, but not limited to, preserving, changing or improving your appearance, such as changing the appearance or texture of your skin);
- Any New FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.
- Allergy serum;
- Anabolic steroids;
- Anorexiants;
- Biologicals;
- Blood and blood plasma;
- Compounds containing no legend items;
- Contraceptive devices;
- Contraceptive drugs which are not medically necessary;
- Human growth hormones;
- Immunizations agents;
- Medication administered by a hospital or a sanitarium which operates a pharmaceutical dispensing facility;
- Norplant contraceptive system (levonorgestrel implant;
- Nutritional and dietary supplements;
- Retin-A for members 30 years of age and older;
- Smoking cessation aids (e.g. nicotine gum and transdermal nicotine patch);
- Topical minoxidil;
- Unit dose drugs when purchased through mail order service;
- Vitamins except those which are medically necessary and require a prescription order.

Copayment – Each Prescription Order may be subject to a Copayment. If the Prescription Order includes more than one covered drug, a separate Copayment will apply to each covered drug. Your Prescription Drug Copayment will be the lesser of your scheduled Copayment amount or the Maximum Allowable Amount. Please see the Schedule of Benefits for the applicable Copayment. If you receive Covered Services from a Non-Network Pharmacy, a Copayment amount will also apply.

Days Supply – The number of days supply of a drug which you may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits.

Payment of Benefits

The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, a Non-Network Pharmacy, or the Mail Service Program. It is also based upon whether you obtain a Generic or Brand Name Prescription Legend Drug. Please see the Schedule of Benefits for the applicable amounts and for applicable limitations on number of days supply.

Note: If you obtain a Brand Name Drug, the Brand Name Drug Copayment will always apply, even in the following situations:

- no Generic Drug equivalent is available;
- the Prescription Order specifies "Dispense as Written;" or
- you chose the Brand Name Drug instead of the Generic Drug Equivalent.

Note: If you choose the Brand Name Drug, or your Provider prescribes a Brand Name Drug and a Generic Formulary Drug is available, you pay the Brand Formulary Drug Copayment. If you choose a Non-Formulary Drug, or your Provider prescribes a Non-Formulary Drug and a Generic Formulary Drug, or Brand Formulary Drug is available, you pay the Non-Formulary Drug Copayment. Where no Generic Drug is available, you are only responsible for the applicable Formulary or Non-Formulary Drug Copayment.

The amounts for which you are responsible are shown in the Schedule of Benefits. No payment will be made by Us for any Covered Service unless the charge exceeds any applicable Deductible and/or Copayment for which you are responsible.

Your Copayment(s) and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by APM and/or the Plan from drug manufacturers or similar vendors.

For Covered Services provided by a Network Pharmacy or through Mail Service, you are responsible for all Deductibles and/or Copayment amounts.

For Covered Services provided by a Non-Network Pharmacy, you will be responsible for the amount(s) shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount.

How to Obtain Prescription Drug Benefits

Network Pharmacy – Present your written Prescription Order from your Physician, and your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to Us with a written request for refund.

Non-Network Pharmacy – You are responsible for payment of the entire amount charged by the Non-Network Pharmacy. You must submit a Prescription Drug claim form to Us for reimbursement consideration. These forms are available from Us or from the Group. You must complete the top section of the form and ask the Non-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, you must attach an itemized receipt to the claim form and submit to Us. The itemized receipt must show:

- Name and address of the Non-Network Pharmacy;
- Patient's name;
- Prescription number;
- Date the prescription was filled;
- Name of the drug;
- Cost of the prescription;
- Quantity of each covered drug or refill dispensed.

You are responsible for the amount shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount.

Anthem Mail Service – Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the Mail Service. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to submit the applicable Deductible and/or Copayment amounts to the Mail Service when you request a prescription or refill.

State Mandated Benefits

These benefits are required to be covered by group health plans in Indiana; they will usually be paid Medicare and Section 1 Medicare Complementary Benefits, but will be paid under Section 2 Major Medical to the extent not paid by Medicare:

Mastectomy Notice

Services for reconstructive surgery following mastectomies are covered including coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages of the mastectomy, including lymphedemas.

All applicable benefit provisions apply, including Deductibles, Copayments and/or co-insurance

Diabetes Self Management Training

Diabetes self-management training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Mammography Screening Services

Benefits are paid for routine screening mammography services. Benefits will also be paid for additional mammography services required for proper evaluation and any ultrasound services for diagnostic screening of breast cancer, if such services are determined to be Medically Necessary by your Physician.

Prostate Screening Services

Benefits are paid for individual routine prostate screening services, including services provided in a Physician's office.

Colorectal Cancer Testing

Benefits for routine colorectal cancer examinations and related laboratory tests for cancer, including services provided in a Physician's office are covered. Examinations and tests will be covered as often as recommended by the current American Cancer Society guidelines or by your Physician.

Morbid Obesity Treatment Services

Covered Services include surgical treatment by a Provider of morbid obesity:

- that has persisted for at least five (5) years; and
- for which nonsurgical treatment that is supervised by a Physician has been unsuccessful for at least eighteen (18) consecutive months.

"Morbid obesity" means:

1. a weight of at least two (2) times the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables;

2. a body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or

3. a body mass index of at least forty (40) kilograms per meter squared without comorbidity.

For purposes of this subsection, body mass index equals weight in kilograms divided by height in meters squared.

10 EXCLUSIONS

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. **We are the final authority for determining if services or supplies are Medically Necessary, or Experimental/Investigative, under Section 2 Major Medical Benefits.**

We do not provide benefits for services, supplies or charges for:

1. Which We or Medicare determine are not Medically Necessary or do not meet Our Medical Policy, clinical coverage guidelines, or benefit policy guidelines;
2. Charges in excess of the Maximum Allowable Amount;
3. Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Us;
4. Supportive devices of the feet; care of flat feet, fallen arches, weak feet, chronic foot strain, and toenails; and treatment of corns, bunions, and calluses except when Medically Necessary including but not limited to foot care for diagnosis of diabetes or for impaired circulation to the lower extremities.
5. Treatment of an injury or illness resulting from participating in a riot.
6. Charges related to suicide or attempted suicide.
7. Treatment of intentionally self-inflicted injuries.
8. Treatment of an injury sustained while flying, except as a fare paying passenger in a regularly scheduled commercial aircraft.
9. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law.
10. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. this exclusion

applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

11. Services or supplies to the extent you are not legally obligated to pay for them.

12. Services provided by any governmental agency to the extent that you are not charged for them, except when this exclusion conflicts with state or federal law.

13. Services or supplies prescribed, ordered, or referred by, or received from, a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

14. Services or supplies received from a dental or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group.

15. Services and supplies for dental care, except as specifically stated as covered.

16. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery including but not limited to cataract surgery, or for soft contact lenses due to a medical condition.

17. For Custodial Care, domiciliary or convalescent care, whether or not recommended or performed by a professional.

18. Rest cures or sanatorium care.

19. Preventive or routine care, including physicals, premarital examinations, and any other routine or periodic examinations, except as specifically stated as covered.

20. Travel, whether or not recommended by a Physician.

21. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Anthem and/or Medicare.

22. Services or supplies that do not qualify for payment under Medicare, unless specifically stated as covered.

23. Any New FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, and/or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, is excluded from coverage for the first 6 months after the date the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may, in its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

24. Related to weight loss or weight loss programs whether or not they are under medical or Physician supervision. Weight loss programs for medical reasons are excluded, except certain surgical treatments of morbid obesity as required by law are Covered Services. Weight loss programs include but are not limited to commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.

25. Services and supplies related to sex transformation or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction; and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

26. Services and supplies related to the treatment of abuse of nicotine from tobacco or other sources.

27. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by Anthem.
28. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.
29. For personal hygiene, environmental control, or convenience items including but not limited to: air conditioners; humidifiers; physical fitness equipment; personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals; charges for failure to keep a scheduled visit; for non-medical self-care except as otherwise stated; purchase or rental of supplies for common household use, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program; for a health spa or similar facility.
30. For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
31. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
32. Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply for left ventricular assist devices (LAVD) when used as a bridge to a heart transplant.
33. Services or supplies that do not qualify for payment under Medicare, unless specifically stated as covered under Section 2 Major Medical or Anthem determines it to be Medically Necessary and not Experimental or Investigational in nature.

11 CLAIMS PAYMENT

How to Obtain Benefits

A claim must be filed for you to get benefits. Many Hospitals, Physicians, and Other Providers will submit your claim for you. If you submit the claim yourself, you should use a claim form.

How Benefits Are Paid

Medicare Complementary Benefits Received in Indiana

If you are a patient at any Medicare participating Hospital, your Medicare Part A and Major Medical claims will be filed for you if you show both Identification Cards.

Most doctors and other Providers will also file your Medicare Part B and Major Medical claims for you if you show both Identification Cards. Make

sure your identification number is shown on the appropriate line of the Medicare claim form.

Occasionally, you may have to file your claims yourself. Indicate your identification number on the appropriate line of the Medicare claim form, and your Major Medical will be processed automatically. After your Medicare benefits have been paid, Medicare will send you an explanation of what they paid and why. Shortly thereafter, you will receive notice indicating what We paid and why.

Medicare Complementary Benefits Received outside of Indiana

Medicare claims must be filed with the Medicare carrier in the state in which the services were performed. The Medicare carrier in that state will send you an Explanation of Medicare Benefits, explaining what Medicare paid. When you receive that explanation, send a copy of it, an itemized statement of charges, and all the numbers on your Identification Card to:

Anthem Blue Cross and Blue Shield

P. O. Box 37010

Louisville, KY 40233-7010

Major Medical

This Plan shares the cost of your medical expenses with you up to the Maximum Allowable Amount. For services subject to a Deductible, you pay a portion of the bill before this Plan begins to pay its share of the balance. Some services are subject to a Copayment, others may be subject to both a Deductible and Copayment.

Many Providers will seek compensation from Us for Covered Services. When using a Provider you are only responsible for Copayments, Deductibles, and non-covered charges. Providers have agreed to accept the Maximum Allowable Amount as payment in full. Copayments are your share of the cost for particular health services, and are generally due at the time you receive the medical service. For Covered Services subject to a Copayment, you pay a portion of the bill and the Plan pays its share of the balance. Refer to the Schedule of Benefits to see what Copayment amount is required for each Covered Service.

The amount you pay may differ by the type of service you receive or by Provider. Refer to the Schedule of Benefits to see what amount you are required to pay for each service. Claims for Covered Services need not be sent to Us in the same order that expenses were incurred.

We will deny that portion of any charge which exceeds the Maximum Allowable Amount.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Certificate. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by ERISA.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

This Certificate is not assignable by the Group without the written consent of the Plan. The coverage and any benefits under this Certificate are not assignable by any Member without the written consent of the Plan, except as provided above.

Notice of Claim

We are not liable under the Certificate, unless We receive written notice that Covered Services have been given to you. The notice must be given to Us by December 31 of the year following that you received the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames

specified in this provision or no benefits will be payable except as otherwise required by law. If we have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for addtional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice by December 31 of the year following that you received the Covered Services will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year from December 31 of the year following that you received the Covered Services, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Many Providers will file for you. If the forms are not available, either send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature

Proof of Claim

Written proof of claim satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of claim is not sent within the time required, the claim will not be reduced or denied if it was not possible to do send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Appeals Procedure

You or your Physician may request a review of a Hospital Inpatient admission, length of stay, procedure, service, level of care, or place of care that was not certified. The Company shall utilize a Physician who did not participate in the original determination not to certify. A decision regarding the Appeal will be completed within the days allowed by law after all information necessary to complete the review has been received.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive. We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by your coverage;
- the amount for which you are responsible (if any);
- general information about your Appeals rights and for ERISA plans, information regarding the right to bring an action after the Appeals process.

12 GENERAL PROVISIONS

Entire Contract

This Certificate, the Group Contract, the Group application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between the Plan and the Group and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Group and any and all statements made to the Group by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

NOTE: The laws of the state in which the Group Contract was issued will apply unless otherwise stated herein.

Form or Content of Certificate

No agent or employee of the Plan is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by an officer of the Plan.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Certificate is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Certificate insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Coordination of Benefits

Applicability

This provision applies when you have health care coverage under more than one Plan. For the purposes of this provision, "Plan" is defined below.

If this provision applies, the Order of Benefit Determination Rules specifies whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

1. will not be reduced when, under the Order of Benefit Determination Rules, this Plan determines its benefits before another Plan; but
2. may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. The reduction is described under the heading "Effects on the Benefits of this Plan."

Definitions

Plan - this Plan and any other arrangement providing health care or benefits for health care through:

1. group insurance or group-type coverage whether insured or uninsured. This includes prepayment group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. coverage under a governmental plan or coverage required or provided by law except Medicare or Medicaid.
3. the medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type Contracts.
4. any other coverage which, as defined by the Employee Retirement Income Security Act of 1974, is a labor-management trustee plan, a

union welfare plan, an employee organization plan or an employee benefit organization.

5. any other coverage provided because of sponsorship by or membership in any other association, union, or similar organization.

"Plan" is not any of the following:

1. Individual or family coverage, including insurance contracts, Subscriber contracts, coverage through health maintenance organizations or other prepayment group practice and individual practice plans which are not group coverage.
2. group or group-type Hospital indemnity benefits of $100.00 per day or less.
3. School accident-type coverage for grammar, high school, and college students for accidents only, including athletic injuries, either on a 24 hour basis or on a "to and from" school basis.

Primary Plan/Secondary Plan - the Order of Benefit Determination Rules state whether this Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Allowable Expense - a necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in this Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When the benefits are reduced under a Primary Plan because a Member does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, Precertification of admissions or services, and preferred Provider arrangements. Only benefit reductions based upon provisions similar to this one and which are contained in the primary Outpatient may be excluded from allowable expenses. This provision shall not be used by a Secondary Plan to refuse to pay benefits because a health maintenance organization (HMO) Member has elected to have health care services provided by a non-HMO Provider and the HMO, pursuant to this Certificate, is not obligated to pay for providing those services.

Allowable Expense does not include any expenses incurred or claims made under the Prescription Drug program of this Plan.

Order of Benefit Determination Rules

When there is a basis for a claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

1. the other Plan has rules coordinating its benefits with those of this Plan; and
2. both those rules and this Plan's rules require that this Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the person as a Subscriber or Member (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent, except that: if the person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

    a. Secondary to the Plan covering the person as a Dependent; and
    b. Primary to the Plan covering the person as other than a Dependent (e.g. a retired employee);

    then the order of benefits is reversed so that the Plan covering the person as an employee, Member, Subscriber or retiree is secondary and the other Plan is primary.

2. Dependent Child/Parents not Separated or Divorced. When this Plan and another Plan cover the same child as a Dependent of parents who are not separated or divorced:

    a. the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
    b. if both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

    However, if the other Plan does not have the rule described in a. immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

3. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

    a. First, the Plan of the parent with custody of the child;
    b. Then, the Plan of the spouse of the parent with custody of the child; and
    c. Finally, the Plan of the parent not having custody of the child.

    However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the Primary Plan has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent will be the Secondary Plan.

4. Joint Custody. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the Order of Benefit Determination Rules outlined in paragraph 2.

5. Active/Inactive Subscriber. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's Dependent. If the other Outpatient does not have this rule and if, as a result, the Outpatients do not agree on the order of benefits, this rule 5 is ignored. This rule does not supersede rule 1 above.

6. Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

    a. First, the benefits of a Plan covering the person as a Subscriber or Member or as that person's Dependent;

b. Second, the benefits under the continuation coverage. If the other Plan does not have the rule described above and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

7. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered the person longer are determined before those of the Plan which covered that person for the shorter term.

Effect on this Plan's Benefits

When a Member is covered under two or more Plans which together pay more than the Allowable expense, the Plan will pay this Plan's benefits according to the Order of Benefit Determination Rules. This Certificate's benefit payments will not be affected when it is primary. However, when this Certificate is secondary under the Order of Benefit Determination Rules, benefits payable will be reduced, if necessary, so that combined benefits of all Plans covering you or your Dependent do not exceed the Allowable Expense.

When this Plan is secondary, you will receive credit during the remainder of the calendar year for the amount by which your benefits are reduced. This credit will not be applied to the extent that would cause you to receive:

1. a combined benefit from all Plans greater than the Allowable Expense; or

2. more benefits during a calendar year than you would receive if there were no other coverage.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Certificate must give the Plan any facts it needs to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under this Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payment made by the Plan is more than it should have paid under this provision, it may recover the excess from one or more of:

1. the persons it has paid or for whom it has paid;

2. insurance companies; or

3. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefit provided in the form of services.

Duplicate Coverage

No Member whose coverage is in effect may also have coverage under an

individual health insurance contract with Us. You may not have an individual Medicare Supplement policy and this Plan. A Member who has such duplicate coverage may keep only one coverage. A Member who chooses not to keep this coverage will receive a refund of any applicable Premium payments that apply to the period of duplicate coverage, minus benefits paid for expenses he or she incurred during the refund period.

Duplicate Payment

If you incur an expense that can be covered under more than one benefit in this Plan, We will not duplicate payment under the various benefits available. However, consecutive payments for Covered Services will be provided as appropriate.

Worker's Compensation

The benefits under this Certificate are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under this Certificate shall not duplicate any benefits to which Members are entitled or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Members shall be paid by or on behalf of the Member to the Plan.

Subrogation and Right of Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.
- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the Providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and We would not have any obligation to pay the Provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf.

Relationship of Parties (Group-Member-Plan)

Neither the Group nor any Member is the agent or representative of the Plan.

The Group is fiduciary agent of the Member. The Plan's notice to the Group will constitute effective notice to the Member. It is the Group's duty to notify the Plan of eligibility data in a timely manner. The Plan is not responsible for payment of Covered Services of Members if the Group fails to provide the Plan with timely notification of Member enrollments or terminations.

Interpretation of Certificate

The laws of the State in which the Certificate is issued shall be applied to the interpretations of this Certificate.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Modifications

By this Certificate, the Group makes the Plan coverage available to eligible Members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Group Contract, or by mutual agreement between the Plan and the Group without the consent or concurrence of any Member. By electing medical and Hospital coverage under the Plan or accepting the Plan benefits, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting agree to all terms, conditions, and provisions hereof.

Clerical Error

Clerical error, whether of the Group or the Plan, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated

Medical Examination

We have the right to have a Physician examine you as often as is reasonably required while We are processing a claim. We will notify you in advance.

Medical Services

We are not liable for the furnishing of Covered Services, but merely for the payment of them. You shall have no claim against Us for acts or omissions of any Provider from whom you receive Covered Services. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Provider Reimbursement

Benefits shown in this Certificate or the Schedule of Benefits for Major Medical Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either Our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts We consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your Payment Maximum mean the amounts actually paid by Us

for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Certificate, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The following provision only applies where the interpretation of this Certificate is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

The Plan, or anyone acting on Our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, We, or anyone acting on Our behalf, has complete discretion to determine the administration of Your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental-Investigative, whether surgery is cosmetic, and whether charges are consistent with our Maximum Allowable Amount. However, a Member may utilize all applicable Member Grievance procedures.

The Plan, or anyone acting on Our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of the Certificate. This includes, without limitation, the power to construe the Group Contract, to determine all questions arising under the Certificate, to resolve Member Grievances and Appeals and to make, establish and amend the rules, regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Group Contract, the Certificate, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Anthem Insurance Companies, Inc. Note

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this policy constitutes a Contract solely between the Group and Anthem Insurance Companies, Inc. (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield Outpatient or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem

other than those obligations created under other provisions of this agreement.

13 MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative . We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a signed Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the grievance from the member or the member's provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, mail it to: Anthem Appeals, P.O. Box 6227, Indianapolis, Indiana 46260-6227, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 5 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but not later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance does not relate to an adverse certification decision (i.e., Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in

writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the appeal for consideration by the appeal panel whether or not You choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting, unless your Appeal qualifies for Expedited Review. Appeals concerning adverse certification decisions or the denial of any other prior authorization required by the Plan will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance . To qualify for an External Grievance all of the following requirements must be met:

- Your Appeal is regarding:
    1. an adverse determination of appropriateness; or
    2. an adverse determination of medical necessity; or
    3. a determination that a proposed service is Experimental/Investigational made by Us or an agent of Ours regarding a service proposed by the treating physician; and
- You or your representative request the External Grievance in writing within forty-five (45) days after You are notified of the Appeal panel's decision concerning your Appeal; and
- The service is not specifically excluded in this Certificate.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is received by Us after the end of the calendar year plus 12 months have passed since the incident leading to your Grievance. We will accept Appeals filed within 60 days after you are notified of our decision concerning your Grievance. We will accept External Grievance requests filed within 45 days after you are notified of our Appeal decision.

Grievances and Appeals by Members of ERISA Plans

If you are covered under a Group plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you must file a Grievance prior to bringing a civil action under 29 U.S.C. 1132 §502(a). An Appeal of a Grievance decision is a voluntary level of review and need not be exhausted prior to filing suit. Any statutes of limitations or other defenses based upon timeliness will be tolled while an Appeal is pending. You will be notified of your right to file a voluntary Appeal if Our response to your Grievance is adverse. Upon your request, We will also provide you with detailed information concerning an Appeal, including how panelists are selected.

Department of Insurance

You have a right, when encountering a problem with Us, to contact the Indiana Department of Insurance, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204, (317) 232-2385.

Underwritten by Anthem Insurance Companies, Inc.

Notice of Privacy Practices

IN (Non-HMO) Privacy Notice (2/03)

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: April 14, 2003

THIS PRIVACY NOTICE IS PROVIDED BY:

Anthem Insurance Companies, Inc. DBA Anthem Blue Cross and Blue Shield ("Anthem"). The Health Insurance Portability and Accountability Act (HIPAA) is a federal law. We are required by HIPAA to provide you with this notice. This notice describes our privacy practices, legal duties, and your rights concerning your Protected Information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect **April 14, 2003**. It will remain in effect unless and until we publish and issue a new notice.

1. **Our Commitment to Your Privacy**

   As a company responsible for the information that we collect about you, your privacy is important to us. We are committed to protecting the confidential nature of your medical information to the fullest extent of the law. In addition to various laws governing your privacy, we have our own privacy policies and procedures in place. These are designed to protect your information. We understand how important it is to protect your privacy. We will continue to make this a priority.

2. **Our Legal Duties**

   We are required by applicable federal and state laws to keep certain information about you private. An example of this is your medical information. We treat your medical and demographic information that we collect as part of providing your coverage, as "Protected Information." It is our policy to maintain the privacy of Protected Information in accordance with HIPAA, except to the extent that applicable state law provides greater privacy protections. This Notice of Privacy Practices was drafted to be consistent with the HIPAA privacy regulation. Any terms not defined in this Notice will have the same meaning as they have in the HIPAA privacy regulation.

   The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a state, or other federal laws, rather than the HIPAA Privacy Regulation, might impose a privacy standard that we are required to follow. For example, where such laws are in place, we will follow more stringent state privacy laws that relate to use and disclosure of Protected Information about HIV or AIDS, mental health, substance abuse, chemical dependency, genetic testing, reproductive rights, etc.

   We reserve the right to change the terms of this notice. We may make the new notice provisions effective for all the Protected Information that we maintain. This includes information that we created or received before we made the changes. Any revised notice will be provided to you by one of the following means. (1) By mail to the named insured under the terms of your coverage. (2) By delivery of the notice by the named insured's employer if you are enrolled in employer-sponsored group insurance coverage. A copy of any revised notice will also be available on Anthem's web site.

Anyone may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact the appropriate office listed at the end of this notice.

3. **Our Primary Uses and Disclosures of Your Protected Information**

   We may use and disclose your Protected Information without your specific authorization for the purposes of treatment, payment, and health care operations. To illustrate:

   - **Treatment Activities.** Activities performed by a health care provider related to the provision, coordination or management of health care provided to you. We do not provide treatment, which is the role of a health care provider (your physician, a hospital or the like). However, we may disclose Protected Information to your health care provider in order for that provider to treat you.
   - **Payment Activities.** Activities undertaken to obtain premiums or to determine or fulfill our responsibilities for coverage and provision of plan benefits. These include activities such as determining eligibility or coverage, utilization review activities, billing, claims management, and collection activities. For example, we may use Protected Information to determine whether a particular medical service given or to be given to you is covered under the terms of your coverage. We may also disclose Protected Information to health care providers or other health plans for their payment activities, such as to coordinate benefits.
   - **Health Care Operation Activities**. Activities such as credentialing, business planning and development, quality assessment and improvement, premium rating, enrollment, underwriting, claims processing, customer service, medical management, fraud and abuse detection, obtaining legal and auditing services, and business management. For example, we may use your Protected Information for underwriting, premium rating or other activities associated with the creation, renewal or replacement of a contract of health insurance or health benefits. We may also disclose Protected Information to other health plans or health care providers for certain health care operation activities of their own as described in the HIPAA privacy regulation. We may also use your Protected Information to give you information about one of our disease/care management programs. We may also give you information about treatment alternatives or other health-related benefits and services that may interest you. If you are enrolled with Anthem through an employer-sponsored group health plan, we or your group health plan may disclose Protected Information to the sponsor of the plan, provided that the group health plan adopts certain protections required by federal law.

   When using and disclosing your Protected Information in our payment and health care operation activities, we may only request, use, and disclose the minimum amount of your Protected Information necessary to complete the activity.

   We may contract with others to assist us with treatment, payment or health care operation activities that involve the use of your Protected Information. Such third parties are referred to as our business associates. We require business associates to agree, in writing, to contract terms. These terms are specifically designed to safeguard Protected Information before it is shared with them. We may also have business associates assist in the activities described in the following section that involve permitted uses and disclosures.

4. **Other Uses and Disclosures of Your Protected Information**

You and on Your Authorization. We must disclose your Protected Information to you. This is described in the Individual Rights section of this notice, below. You may also give us written authorization to use or disclose your Protected Information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, we may not use or disclose your Protected Information for any reason except as described in this notice.

The following is a description of other possible ways we may (and are permitted by law to) use and/or disclose your Protected Information without your specific authorization.

- **Family and Friends.** If you are unavailable to agree, we may disclose your Protected Information to a family member, friend or other person when the situation indicates that disclosure would be in your best interest. This includes a medical emergency or disaster relief. If you are available and agree, we may disclose your Protected Information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care.
- **Research. Death. Organ Donation.** We may use or disclose your Protected Information for research purposes in limited circumstances specified in the HIPAA privacy regulation. We may disclose the Protected Information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.
- **Public Health and Safety.** We may disclose some of your Protected Information permitted by state law to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your Protected Information to a government agency that oversees the health care system or government programs or its contractors, and to public health authorities for public health purposes. We may disclose your Protected Information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.
- **Required by Law.** We may use or disclose your Protected Information when we are required to do so by law. For example, we must disclose your Protected Information to the U.S. Department of Health and Human Services upon request in order to determine if we are in compliance with federal privacy laws. We may disclose your Protected Information to comply with workers' compensation or similar laws.
- **Legal Process and Proceedings.** We may disclose your Protected Information in response to a court or administrative order, subpoena, discovery request, or other lawful process. These disclosures are subject to certain administrative requirements imposed by the HIPAA privacy regulation and permitted by state law.
- **Law Enforcement.** We may disclose limited information to a law enforcement official concerning the Protected Information of a suspect, fugitive, material witness, crime victim or missing person subject to certain administrative requirements approved by the HIPAA privacy regulation and permitted by state law. We may disclose the Protected Information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances specified by the HIPAA privacy regulation. We may also disclose Protected Information where necessary to assist law enforcement officials to

capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

- **Military and National Security**. We may disclose to military authorities the Protected Information of Armed Forces personnel under certain circumstances specified by the HIPAA privacy regulation. We may also disclose to authorized federal officials Protected Information required for lawful intelligence, counterintelligence, and other national security activities.

5. **Individual Rights**

- **Access.** You have the right to inspect and obtain copies of your Protected Information for as long as your information is maintained in our designated record set. Our designated record set includes records from our enrollment, billing, claims, and medical management systems, as well as any other records we maintain in order to make decisions about your health care benefits. Your right of access to Protected Information does not extend to certain information. This includes information contained in psychotherapy notes or information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative proceeding.

  You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. We reserve the right to charge a reasonable fee for copies of Protected Information that we provide.

  Any request to exercise your individual right of access to your Protected Information must be in writing. You may obtain a form to request access by using the contact information listed at the end of this notice. We will respond to your request for access within 30 days of receiving the request. If all or any part of your request is denied, our response will detail any appeal rights you may have with respect to that decision.

  Notwithstanding the formal process for your right of access, certain information related to enrollment and claims processing may be available to you by contacting our Member Service representatives as part of our normal customer service function. You should contact Member Services first to see if your request can be satisfied as a customer service request.

- **Amendment.** You have the right to request that we amend your Protected Information that we keep in our designated record set if you believe it is inaccurate. A request that your Protected Information be amended must be done in writing. You may obtain a form to request amendment by using the contact information listed at the end of this notice. We will respond to your request for amendment within 60 days of receiving the request.

  If we accept your request to amend the information, we will notify you. We will make reasonable efforts to inform other persons, including those identified by you as having received your Protected Information and needing the amendment. We will also include the changes in any future disclosure of that information. If we deny your request for reasons permitted by the HIPAA privacy regulations, our notice to you will explain any appeal rights you may have with respect to that decision.

  Notwithstanding the formal process for your right of amendment, certain information related to enrollment and claims processing may be corrected by contacting our Member Service representatives. This is part of our normal customer service function. You should contact Member Services first to see if your request can be satisfied as a customer service request.

- **Disclosure Accounting.** You have the right to request and receive an accounting of disclosures of your Protected Information made by us. We are not required under the HIPAA privacy regulation to provide you with an accounting of certain types of disclosures.

  The most significant types include:

  - Any disclosures made prior to April 14, 2003
  - Disclosures for treatment, payment or health care operations activities
  - Disclosures to you or pursuant to your authorization
  - Disclosures to persons involved in your care
  - Disclosures for disaster relief, national security or intelligence purposes
  - Disclosures that are incidental to a permitted use or disclosure

  To request an accounting of disclosures, you must send a written request to the contact office listed at the end of this notice. You may request one such accounting at no charge every 12 months. You may request that the accounting cover up to a 6-year period of reportable disclosures from the date of your request. We will respond within 60 days of your request. We reserve the right to impose a reasonable charge for requests made more than once per year.
- **Confidential Communications.** You may believe that you will be in danger if we communicate Protected Information to you to your address of record. If so, you have the right to request that we communicate with you about your Protected Information at an alternative location or by alternate means. We will make reasonable efforts to accommodate your request if you specify an alternate address. To request a confidential communication, you must direct your request to the contact office listed at the end of this notice.
- **Restriction Request.** You have the right to request that we restrict the use or disclosure of your Protected Information for treatment, payment or health care operation activities. You also have the right to request that we restrict disclosures to relatives, friends, or other individuals that may be involved in your care or payment for your health care. We are not required to agree to such a request for restriction. To request a restriction, you must direct your request to the contact office listed at the end of this notice.

6. **Contacting Us**

   Please contact Anthem Member Services using the contact information on your ID card:

   - If you want a printed copy of our current notice
   - If you want to access your Protected Information
   - If you want to request an amendment to your Protected Information
   - If you want to request an accounting of our disclosures of your Protected Information
   - If you want us to communicate with you at an alternative address or by alternate means because you believe that you are endangered
   - If you want to request a restriction on our use and disclosure of your Protected Information

   If you have questions, concerns, or complaints about this notice or our privacy practices, please contact:

   Midwest Privacy Operations Unit

   (800) 880-1254

   As described in section 5 of this notice, you may also be able to access or amend certain information in our enrollment, billing, or claims systems by contacting Member Services using the contact information on your ID card.

7. **Contacting the Department of Health and Human Services**

   You may also submit a written complaint to the Department of Health and Human Services if you believe your privacy rights have been violated.

   Anthem maintains and enforces a policy of non-retaliation against our members, members of our workforce, or members of the public who bring breaches (or potential breaches) of this notice to the attention of our privacy officer or the Department of Health and Human Services.

For more information, visit our web site at anthem.com.